President's Emergency Plan for AIDS Relief

Five-Year Strategy for Zambia

December 2004

Acronyms

ABC	Behavior change theory for preventing transmission of HIV/AIDS by practicing three principles: Abstinence, Be Faithful, and Correct and Consistent Use of Condoms
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral Drug(s)
CBO	Community-based Organization
CBOH	Central Board of Health
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHAZ	Churches Health Association of Zambia
CSW	Commercial Sex Worker
CT	Counseling and Testing
DHS	Demographic and Health Survey
DOD	United States Department of Defense
EPI	Expanded Program of Immunization
FBO	Faith-based Organization
GAVI	Global Alliance for Vaccines and Immunizations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria (also known as Global Fund)
GRZ	Government of the Republic of Zambia
HBC	Home-based Care
ITN	Insecticide Treated Bed nets
LDT	Long-distance Truck Drivers
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NAC	National HIV/AIDS/STI/TB Council
NGO	Non-governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PLWHA	Person(s) Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child HIV Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
ZDF	Zambian Defense Force

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I. INTRODUCTION AND BACKGROUND

1.1. VISION

VISION: Reverse the tide of HIV/AIDS in Zambia through universal access to and use of a full range of high quality HIV/AIDS services and resources

With 15.6% of the adult population infected with HIV, Zambia faces its most critical health, development and humanitarian crisis to date. In response to this emergency, the U.S. Mission to Zambia[1] (hereafter referred to as the USG) is applying the strategic approaches, principles and resources of the President's Emergency Plan for AIDS Relief (Emergency Plan). The Emergency Plan in Zambia will be closely aligned with the Zambia National HIV/AIDS/STI/TB Strategy, which includes all Emergency Plan program areas. The guiding strategic principles in Zambia to implement the Emergency Plan include:

- Introduce new and innovative approaches;
- Develop new, strong HIV/AIDS leadership in Zambia;
- Use evidence-based policy decisions;
- Respond to local needs and Zambian government policies and strategies;
- Develop and strengthen prevention, treatment, and care integrated HIV/AIDS services;
- Support sustainable HIV/AIDS health care networks;
- Support and use prevention lessons learned from the "ABC" (Abstinence, Be faithful, and, as appropriate, correctly and consistently use Condoms) model;
- Support activities that combat stigma and denial;
- Seek new strategies to encourage HIV/AIDS testing;
- Encourage the involvement of people infected with and affected by HIV/AIDS;
- Encourage and strengthen the participation and leadership of faith-based, community-based, and nongovernmental organizations; and,
- Encourage coordination with other collaborating partners while maintaining focus on the objectives and principles of the Emergency Plan.

As a partner in the National HIV/AIDS/STI/TB Strategic Plan that responds effectively to the HIV/AIDS emergency in Zambia, the USG will contribute significantly and rapidly to help transform Zambia into a nation whose citizens are actively seeking and accessing HIV/AIDS services as close to the home as possible without the fear of stigma.

Emerging from this collaboration will be an integrated network of uninterrupted and sustainable service delivery sites through government health facilities, faith-based organizations (FBOs), community-based organizations (CBOs), and the private sector, that prevent new infections, care for persons infected with or affected by HIV/AIDS - including orphans and vulnerable children (OVCs) and persons living with HIV/AIDS (PLWHA), and provide anti-retroviral treatment (ART) for people eligible for treatment. The five-year strategy for the Emergency Plan in Zambia that follows describes strategic approaches the USG will use to work closely with the Government of the Republic of Zambia (GRZ) to establish a sustainable, integrated, and accessible HIV/AIDS prevention, treatment, and care services network.

[1] Present USG agencies include the Centers for Disease Control and Prevention (CDC), US Department of Defense (DOD), Peace Corps, Department of State, and the US Agency for International Development (USAID).

1.2. USG TARGETS IN ZAMBIA

The Emergency Plan in Zambia's five-year numeric targets for prevention, treatment, and care are included in the table below.

President's Emergency Plan Targets for 2004 – 2008							
Target Area	2004	2005	2006	2007	2008	2009	2010
Total # Infections averted	TO BE MODELED						398,500
# Infections averted: PMTCT	TO BE MODELED						
# Infections averted: Other (not PMTCT)	TO BE MODELED						
Total # receiving Care and Support	301,600	350,500	422,000	505,500	600,000	n/a	
# OVC receiving Care and Support	226,000	250,500	290,000	328,500	378,000		
# receiving Palliative Care	75,600	100,000	132,000	177,000	222,000		
# receiving ART	16,000	30,000	50,000	85,000	120,000		

1.3. THE AIDS CRISIS IN ZAMBIA

A. Basic Indicators of Epidemic

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates 920,000 people in Zambia are infected with HIV out of a total population of approximately 10 million. The number of persons dying as a result of AIDS is estimated at 89,000 per year, leaving behind a growing number of AIDS orphans, currently estimated at 630,000.[2]

The Zambian national HIV prevalence rate among adults aged 15-49 is 15.6%, with 18% of women and 13% of men infected countrywide.

Prevalence is significantly higher in urban areas (23.1%) compared to rural areas (10.8%), and reaches 31.3 % in Livingstone and 26.6% in Ndola. There is wide regional variation within the country with HIV prevalence lowest in Northern (8%) and North-Western (9%) provinces and highest in Lusaka (22%), Copperbelt (20%) and Southern (18%) provinces.

In Zambia, high prevalence rates are fueled by early initiation of sex, unprotected sex with non-regular partners, low incidence of condom use

[2] 2004 Report of the Global AIDS Epidemic, UNAIDS, June 2004

among high risk groups and individuals, sexual violence against women, and poverty that forces women and girls to sell sex for food, good grades, small gifts, or money.

According to the Zambia 2001-2002 Demographic and Health Survey (DHS), the HIV prevalence level is already 6.6% for females between 15-19 years of age. HIV prevalence is very high among young women aged 15-24, with 11.2% HIV infected compared to only 3% among men of the same age. The HIV prevalence rate more than doubles to 16% among women 20-24 years of age.

Antenatal Care (ANC) surveillance data indicate a plateauing of prevalence rates since 1994 with a steady trend in prevalence among pregnant women from 20.0% in 1994, to 18.6% in 1998 and 19.1% in 2002. One in five pregnant women is HIV positive, with an annualized 5.5% seroconversion of urban pregnant women in the last 100 days of pregnancy.

The most at risk individual in Zambia, however, is the seronegative partner in a discordant couple. Annually there is an 11.8% seroconversion of negative partners.[3] It is estimated that 21% of couples are discordant in Lusaka.[4]

Knowledge of HIV/AIDS is fairly universal in Zambia. The DHS conducted in Zambia in 1996 and 2002 reported that the proportion of men and women having ever heard of AIDS remained at 99%. The 2002 survey showed that 77.9% of women and 85.5% of men knew of two or more ways of avoiding HIV/AIDS. From 1996 to 2002, the percentage of Zambians that believed that there was no way to prevent HIV/AIDS increased for men from 2.3% to 4.2% and decreased for women from 8.6% to 6.1%.

The DHS also showed evidence of a reduction in the number of sexual partners over time. The proportions of unmarried men and women reporting more than one sexual partner decreased from 32.5% to 17.1% and 6.7% to 2.6% respectively. Conversely, the percentage of married women and men who reported having more than one sexual partner in the last 12 months increased slightly from 1.5% to 1.8% and 18.2% to 19.2%, respectively.

Other groups at comparatively high risk include highly mobile populations such as migrant workers, sex workers, long distance truck drivers, minibus drivers, refugees, prisoners, uniformed personnel (such as the military and police), and fishmongers.

One in five women (19%) admitted exchanging money for sex in their last encounter with a non-regular partner. The median age of sex workers is 23 with the average age at first sex for money at 17. Sex workers have a mean number of 2.7 clients a week, with only half (55.3%) using a condom with their last paying client. A mere 13.3% of sex workers have ever been tested for HIV and over half was diagnosed with at least one sexually transmitted infection (STI). Given the high STI and HIV rates in Zambia, commercial sex work is a very dangerous activity. Only 15.3% of men who tested positive for syphilis having paid for sex and only 22% of men with a STI having used a condom.

Twenty-two percent of long distance truck drivers (LDTs) and 27% of mini bus drivers had sex with a sex worker in the last 12 months. While 93.5% of LDTs reported using a condom at last sex with a sex worker, only 73% of mini bus drivers used one. Nearly thirteen percent (12.5%) of LDTs and 26.5% of minibus drivers reported symptoms of an STI.

[3] *N Engl J Med. 2000 Mar 30;342(13):921-9*

[4] Journal of Virology, January 2002, p. 397-405, Vol. 76, No. 1. Note that observed frequency of discordant couples in cross-sectional survey is less than initial frequency when 'boy first meets girl', since over time discordant couples produce an incident case and become concordant.

Fishmongers, refugees, and prisoners are at special risk for contracting HIV. Fishmongers sell fish for sex to local traders. Refugees do not have access to prevention, treatment, and care services available to the general population. Prisoners are exposed to rape and sexual abuse from other prisoners and have limited access to health care, health messages or condoms.

No prevalence studies have been conducted for the military or police. In one survey along borders and high transit routes, only 21.8% of uniformed personnel, mostly police, reported ever having been tested for HIV.

Approximately 1,700 Zambian soldiers participate in United Nations Peacekeeping missions around the world. In addition, the lack of adequate military family housing in Zambia keeps the families of deployed soldiers separated for up to four years. The use of commercial sex workers by soldiers and/or those separated from their families due to inadequate housing is thought to be significant. Given this situation, members of the Zambian Defense Force (ZDF) are considered to be at high risk for exposure to HIV. Until recently there have been no proactive HIV/AIDS prevention campaigns focused on being faithful during military service.

Confounding the treatment and care of HIV/AIDS patients is the increase in tuberculosis (TB). Factors contributing to the 20% annual increase in TB in Zambia include the HIV epidemic where over 50% of the cases may be co-infected. A study at the University Teaching Hospital (UTH) in Lusaka found that 68% of all TB patients on treatment are HIV positive. The number of TB cases remained relatively stable from 1964 to 1984 between 100 to 120 cases per 100,000 population. By the year 2000, there were 512 TB cases per 100,000 Zambians. The annual risk of infection is estimated by the Ministry of Health (MOH) to be 2.5%. The greatest proportion of TB cases in 2000 occurred in Lusaka Province (36%), followed by Copperbelt with 24% of the cases, and Southern Province with 11%. The fewest numbers of TB cases were found in North Western Province (3%).

B. Overarching Response of HIV/AIDS in Zambia

Zambia is experiencing the health, economic and social impacts of a mature HIV/AIDS epidemic. The epidemic has affected all aspects of social and economic growth in the country. It has devastated individual families, weakened all areas of the public sector, and threatened long-term national development. Despite some evidence that the epidemic may have reached a plateau, there remains an urgent need for an integrated response from all sectors of the GRZ, FBOs, NGOs, the private sector, and collaborating agencies.

Responding to the urgency of the epidemic, the GRZ is well on its way to achieving the "Three Ones[5]." The GRZ developed and is currently implementing a National HIV/AIDS/STI/TB strategic plan for 2002- 2005. This plan established a national coordinating body - the National HIV/AIDS/STI/TB Council (NAC) to provide national leadership coordinating and supporting planning, monitoring, and resource mobilization. The NAC is comprised of broad representation from numerous government ministries and civil society. The NAC drafted a National AIDS Policy, finalized a National Monitoring and Evaluation (M&E) strategy, and began to plan for the next five-year strategy. The GRZ, in collaboration with its partners, instituted one M&E plan to complement the National HIV/AIDS/STI/TB Strategy.

Currently, the NAC manages 14 Technical Working Groups and provides support to 9

[5] The Three Ones: Principles for the coordination of national AIDS responses – One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One national AIDS Coordinating Authority with a broad-based multisectoral mandate; One agreed country-level Monitoring and Evaluation System.

Provincial AIDS Task Forces, and 72 District AIDS Task Forces. The USG is well represented on the Technical Working Groups. While some of these coordinating mechanisms are functioning well, most are still not fully operational.

In support of the GRZ's strategic plan, there are currently 29 cooperating partner agencies contributing directly and indirectly to reducing the impact of the HIV/AIDS epidemic. The United Kingdom (UK) and U.S. are the largest bilateral donors in the fight against AIDS. Donors are coordinated at the highest level through an HIV/AIDS Expanded Theme Group led by the Minister of Health and UNAIDS, through Technical Working Groups implemented by NAC, and numerous topic-specific committees and meetings.

The Country Coordinating Mechanism (CCM) for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) directs planning and coordination of national Global Fund activities. It has a diverse membership including the NAC, MOH, National Malaria Control Program, GRZ ministries, nongovernmental organizations (NGOs), FBOs, CBOs, youth groups, PLWHA advocacy groups, the private sector, and multilateral and bilateral donors. Donors are currently represented on the CCM by the USG and the Netherlands. USG provides technical assistance to the CCM. The Global Fund provides US$ 42 million over 2 yrs, including approximately $2 million for anti-retroviral drugs (ARVs) and $1.1 million for STI drugs and other supplies in the first year. The Global Fund works through 4 principal recipients: MOH (for public health sector); the Ministry of Finance & National Planning (for other government ministries); the Churches Health Association of Zambia (CHAZ; for faith-based groups); and the Zambia National AIDS Network (ZNAN; for NGOs). The Global Fund supports a wide range of prevention, treatment, and care activities, including the Zambian National Tuberculosis (TB) Program.

The World Bank's $42M six-year Zambia National Response to AIDS (ZANARA) Project supports the Community Response to AIDS (CRAIDS) small-grant fund and NAC workplace programs for government ministries.

The Ministry of Health (MOH) provides health sector oversight for policy, planning, legislation, resource mobilization, external relations, and monitoring and evaluation. The National Orphans and Vulnerable Children (OVC) Steering Committee provides leadership, policy guidance, and resource mobilization on OVC issues. The OVC Steering Committee includes government ministries, child welfare networks, NGOs, and FBOs. The United Nations Children's Fund (UNICEF) represents the donors on the Steering Committee, which the USG supports through a grant to UNICEF. The OVC Secretariat is the Ministry of Sport, Youth and Child Development.

The USG maintains a close working relationship with GRZ and other agency implementers. Decisions are made by a consensus-building process. The USG will continue to work within the GRZ's management style of building consensus.

In implementing the Emergency Plan, the USG will take advantage of the fact that the health system in Zambia is organized around the concept of a network model comprised of a public sector network of central facilities, tertiary, provincial, and district hospitals, health centers, neighborhood health committees supplemented by private facilities, which are often faith-based and workplace programs.

On the frontlines in the fight are hundreds of FBOs and CBOs that are committed to implementing prevention activities to mitigate the impact of the epidemic and improve the lives of people infected with or affected by HIV/AIDS. CHAZ includes FBO hospitals and clinics, many of which are also contracted to serve as GRZ health facilities. The 2004 OVC Situation

Analysis identified 538 FBOs/CBOs/NGOs providing care and support to OVCs. Numerous FBOs provide home-based and hospice care for those chronically ill with AIDS.

A major constraint to effectively responding to the epidemic is the lack of sufficient human capacity. It is extremely difficult to recruit and retain trained doctors, nurses, clinical officers, technicians and others. Most health facilities lack adequate staff to manage and treat the HIV/AIDS related cases. Zambia, like many other countries in the region, suffers from a "brain drain" with medical and health professionals leaving Zambia for higher paying positions in other countries. Restrictions on civil service hiring are imposed as conditions of debt relief, which adversely affects the health sector. Attrition due to HIV/AIDS deaths adds to the problem.

There are major deficiencies in the GRZ's and ZDF's health system infrastructure, including laboratories and inconsistent drug supply. Many laboratories stand empty without testing equipment or necessary laboratory supplies. Civilian and military hospitals and clinics often do not have sufficient medicine to properly treat patients.

Stigma remains a silent but powerful barrier to fighting the HIV/AIDS epidemic in Zambia. The continuing stigma of HIV/AIDS affects prevention, treatment, and care. Reluctance to break the wall of silence mutes prevention messages. The prospect of ostracism reduces the number of those seeking counseling and testing, limiting the patient population for treatment programs. Stigma and ignorance also reduce community support for PLWHAs and their affected families. Embarrassment and shame, linked to sexual behavior, are still strongly felt.

Risky cultural and sexual practices, beliefs, and norms promote the spread of the HIV/AIDS virus. Zambia is a deeply traditional society that places a high value on conformity, which discourages many from testing for HIV status. Harmful cultural practices include sexual cleansing, which requires a widow or widower to have intercourse with her, or her deceased spouse's siblings. Women in long-term relationships are prevented from demanding condom usage or denying dry sex due to social norms. Destructive beliefs, such as the myth that sex with a virgin cures HIV/AIDS, persist.

II. CRITICAL INTERVENTIONS

2.1. INTRODUCTION

Critical interventions in Zambia will cover prevention, treatment, and care. The critical intervention strategies of the Emergency Plan in Zambia will result in:

- Rapidly scaling up existing HIV/AIDS prevention, treatment, and care services;
- Building capacity and systems for long-term sustainability of HIV/AIDS prevention, treatment, and care services; and
- Advancing policy initiatives and leadership that support HIV/AIDS prevention, treatment, and care services.

Several crosscutting issues are considered in the design of the critical interventions of the Emergency Plan in Zambia's strategic plan. These include:

- Human Capacity Development
- Sustainability and New Partners
- The Role of the Private Sector
- Stigma and Discrimination
- Gender
- Twinning with other institutions

A. Human Capacity Development

Rapid sustainable response to the HIV/AIDS epidemic in Zambia requires scaling up of existing prevention, treatment, and care services and expansion of the human resource base. Sustainability of programs depend heavily on the Emergency Plan's continued support for human capacity development activities, from training trainers to assisting policy development regarding human resources. Training and supervision of new and existing staff, staff retention, and active recruitment of potential staff contribute significantly to the Emergency Plan's goal to establish sustainable and accessible HIV/AIDS services in Zambia.

B. Sustainability and New Partnerships

In order to create a health system network that can sustain comprehensive, integrated HIV/AIDS services, the strategy focuses on technical assistance and training for an expanded network of new partners, including FBOs, CBOs, and private and public sector groups to close the human capacity gap and lead to a sustainable network of prevention, treatment, and care providers. This requires building the institutional, programmatic, and financial management capacity of these organizations.

C. Role of the Private Sector

The private sector in Zambia, including private health care providers, plays an active role in the fight against HIV/AIDS. The USG supports 2 of the largest companies in the country, Dunavant Cotton and Konkola Copper Mines (KCM), in establishing workplace HIV/AIDS programs for their employees, their families, and members of surrounding communities. Through this two-company initiative, over 135,000 persons benefit from HIV/AIDS prevention, treatment, and care activities. Through expansion of such partnerships in the private sector, the USG will target difficult to reach rural and mobile workers.

D. Stigma and Discrimination

One of the greatest barriers to stopping HIV/AIDS from spreading is the fear associated with stigma. However, leadership in the area of stigma reduction continues to grow in Zambia. For example, President Mwanawasa has instructed his cabinet to include HIV/AIDS in all remarks. His wife plays an instrumental role in energizing women, including both women leaders

and the wives of government officials, to publicly lead in the fight against HIV/AIDS. Generating strong high-level leadership remains necessary in order to turn the tide of HIV/AIDS in Zambia.

E. Gender

Gender continues to play a negative role in prevention, treatment, and care for HIV/AIDS. In the formulation of the Emergency Plan in Zambia's strategic plan, the role of gender in the HIV/AIDS epidemic and relevant gender issues influenced the strategic approaches selected for implementation. Strategies targeted to protecting young women and encouraging male responsibility and participation are incorporated into the Strategic Plan at the national and community levels. These include:

- ABC education
- Life skills and livelihood training
- Reduction in cross-generational sexual relations
- Testing for discordant couples accompanied by couples counseling
- Parental involvement
- Male role models
- Reduction in child sexual abuse
- Ensuring post-exposure prophylaxis for rape
- BCC campaigns targeting high risk males

F. Twinning

In order to respond to the need for network strengthening and address the human capacity shortfall, the Emergency Plan strategy focuses on the mutually beneficial twinning of Zambian health institutions with U.S. and regional health institutions and universities. Twinning is planned between public, private and military institutions in areas such as pediatric ART, palliative care, and HIV/AIDS services for the military.

2.2. PREVENTION

Prevention Objective: Avert 398,500 HIV infections in Zambia by 2010

A. Specific Opportunities and Challenges

Nearly 100% of adult Zambians have heard of AIDS and over half know of at least two ways of preventing transmission. Nevertheless, HIV/AIDS remains at pandemic levels in Zambia, where women are affected at a substantially greater rate than men. The GRZ national strategy is based on the recognition that a significant portion of people aged 15-44 is engaged in high-risk behaviors. It gives high priority to reducing high-risk behavior through the ABC approach to prevention.

Initial efforts by the GRZ to address PMTCT in the public, private and FBO supported health sectors began in 1999. The GRZ developed a comprehensive Strategic Framework for the Expansion of PMTCT Services through the community, as well as national guidelines and training materials for implementation of PMTCT programs that encompasses all public, private and FBO health sectors. An important expansion to the guidelines is the adoption of an "Opt Out" approach to counseling and testing in the antenatal setting. The USG has been a significant PMTCT partner since the beginning of PMTCT services in Zambia.

Beginning in 2000, efforts to strengthen infection prevention practices began in provincial hospitals and in curriculum revision for basic nursing education. At the same time, the national Expanded Program of Immunization (EPI) adopted a much more aggressive program on injection safety and, with funding from the Global Alliance for Vaccines and Immunizations (GAVI), launched a national program to strengthen injection safety, including introducing auto-disposable syringes and sharps disposal boxes to the immunization program. The GRZ also developed hospital accreditation standards,

which included procedures for the control of hazardous materials and wastes and the disposal of medical waste. The National Hospital Policy also includes reference to infection prevention standards. Zambia's National Infection Prevention Guidelines, which incorporate the principles of injection safety, were developed and launched in the fall of 2003 with USG assistance.

The Emergency Plan in Zambia is designed to address the challenges to prevention and capitalize on the opportunities described above in order to achieve its goal of preventing 398,500 new HIV infections by 2010. Evidence-based prevention programs employ best practices and appropriately tailored and targeted interventions for specific populations including youth, women, men, and priority groups such as discordant couples, commercial sex workers, members of the uniformed services, truck and minibus drivers, migrant workers, prisoners, and fish traders.

Key elements of the strategy include increasing the availability of PMTCT services, prevention programs for youth, and high-risk populations and decreasing the incidence of medical transmission of HIV. Building an extensive integrated referral network between PMTCT programs, counseling and testing (CT) centers, TB/STI treatment clinics and HIV treatment sites is a guiding principle. This service delivery integration stimulates a cycle that reduces stigma and fear and encourages testing, thus amplifying prevention efforts.

The USG approach focuses on multiple behavior change activities at national, as well as community levels, to change harmful social practices that contribute to the spread of HIV. The USG also focuses strongly on the use of volunteers and the private sector to spread prevention messages in the rural, hard-to-reach areas. By establishing workplace HIV/AIDS programs, the private sector plays a significant role in reaching the 2-7-10 targets and the national targets. Prevention in the rural areas is critical to begin dissolving myths surrounding HIV and traditional practices that promise HIV prevention or cure. Stigma reduction and gender equality are two areas aggressively addressed to achieve lasting results in reducing the number of new infections. Interventions are designed to strengthen existing indigenous responses to the epidemic while supporting community structures that positively influence social and community norms in order to reduce high-risk behavior.

The Emergency Plan also includes specific interventions to strengthen health care services to reduce HIV transmission. It supports the health infrastructure required for infection control programs. It also supports efforts to reduce medical transmission of infection, and builds links health care workers treating TB and STIs to prevention of mother-to-child infection transmission services. Prevention strategies and activities are integrated with those for treatment and care to stimulate a cycle that reduces stigma and fear, creates incentives for testing, and thus amplifies prevention efforts.

B. USG Strategic Approaches Given USG Comparative Advantages

1. Rapidly scale up existing prevention services

The rapid scale-up of existing prevention services is an urgent priority of the Emergency Plan in Zambia. Although the Emergency Plan seeks long-term development of a sustainable national program, the short-term objective is to respond to the epidemic rapidly through the expansion of current activities. The strategy takes advantage of the many excellent programs already established by the Ministry of Health, faith-based and community-based organizations, and NGOs in the area of abstinence promotion, behavior change, and prevention of HIV transmission from mother to child.

The Emergency Plan will scale up programs in the following priority areas:

Prevention of HIV transmission from mother-to-child (PMTCT): The Emergency Plan in Zambia will (a) scale up existing PMTCT programs by rapidly mobilizing resources; (b) support site expansion to achieve complete geographic coverage; (c) improve the quality of services; (d) strengthen national program planning and oversight; (e) strengthen referral links among health care providers; (f) support HIV rapid testing during labor and delivery for women with unknown HIV status; (g) ensure effective supply chain management for the range of PMTCT-related products and equipment; (h) link of network to care; (i) increase knowledge and demand for services through targeted behavior change communication and community mobilization; (j) link PMTCT programs to include treatment for HIV-infected mothers and other members of the child's immediate family; and (k) support access to family planning services post-delivery.

Prevention of HIV infection through abstinence and behavior change in youth: The USG will support the abstinence objective of the GRZ's National HIV/AIDS Intervention Strategy, "Sexual abstinence among youth and unmarried people promoted" by supporting (a) the development of communication campaigns targeting and involving youth on the importance of sexual abstinence; (b) the dissemination of information in a well-targeted manner through FBO and community partners and the integration of HIV/AIDS education in all institutions of learning, youth livelihood training, and OVC programs; and c) the creation and strengthening of community and peer norms. The Emergency Plan will facilitate the scale up of faith-based prevention interventions by building on faith-based leaders' natural role in the community as counselors, and by providing them with training and tools to reach more of their constituency.

Prevention of HIV infection through faithfulness and partner reduction: For adults, prevention activities that support and promote faithfulness will be implemented through FBOs and clergy, workplace programs, traditional leaders, existing agricultural extension workers, and the mass media. This is critical in Zambia, where traditional practices include having multiple sexual partners, performing sexual cleansing of widows/widowers, and having sex with virgins to "cure" HIV.

Prevention of HIV infection through links to VCT, targeted outreach, STI diagnosis and treatment, and messages promoting consistent condom use to priority populations: The USG will support rapid scale up activities that target specific at-risk populations with outreach, partner reduction messages, STI and CT services, and consistent condom use. These groups include commercial sex workers, sexually active discordant couples, uniformed personnel, truckers and others. Since the HIV negative member of a discordant couple is at very high risk for HIV/AIDS, the Emergency Plan in Zambia expanded the "B" of being faithful to the 4 "Bs" – (1) Be Tested; (2) Be Aware of Your Partner's Status; (3) Be Faithful; and (4) Be Safer. The USG also supports the social marketing of condoms to the priority groups. Biologic and Behavior Surveillance Surveys will track changes in behavior, STI and HIV infection rates among these groups.

Prevention of HIV infections through safe blood, improved medical practices and post-exposure prophylaxis: The USG will provide technical assistance, supplies and training to prevent medical transmission of HIV and improve the quality of services through the network model. The USG will support improved blood safety, increase the use of safe injection practices, ensure the practice of universal precautions, and increase the availability and use of post-exposure prophylaxis. These activities are part of national plans and priorities for blood safety and infection prevention and the USG will

work closely with the Ministry of Health and associated stakeholders. The Emergency Plan will also support training, provide supplies, and provide technical assistance to the Zambian National Blood Transfusion Service and National Infection Prevention Working Group.

2. Build capacity for effective long-term prevention programs

The USG will seek to develop institutional capacity to (a) promote the ABC model; (b) develop interventions for high-risk groups; (c) implement activities to reach mobile populations; (d) improve diagnosis and treatment of STIs; (e) develop and strengthen institutional capacity of implementing organizations; (f) promote male involvement and responsibility;(g) promote and train for parent and child communication; and (h) increase couples counseling. The USG supports activities to strengthen the capacity of local FBOs, CBOs, NGOs, and traditional and other leaders to play important roles in implementing prevention strategies.

3. Advance policy initiatives and leadership that create enabling environments for the prevention of HIV infections

The Emergency Plan will support the development and implementation of strong policies and effective legislation. The USG will foster strong religious, traditional, and political leadership that: (a) protects against stigma and discrimination, particularly within key settings such as workplaces, schools and the military; (b) permits/encourages routine testing while applying the principles of confidentiality and opting-out; (c) increases human resources, including broadening of responsibility of HIV testing and counseling to lower levels of care; (d) improves access to health information and care, including for traditionally underserved populations such as women, the poor and the disabled, prisoners and refugees; (e) promotes gender equality; (f) reviews, revises, and enforces laws relating to sexual violence against minors, including strategies to more effectively protect young victims and punish perpetrators; and (g) supports abstinence until marriage and fidelity within marriage.

2.3. TREATMENT

Treatment Objective: 120,000 receiving ART by 2008

A. Specific Opportunities and Challenges

An estimated 200,000 persons in Zambia need HIV treatment that includes antiretroviral therapy (ART[6]).

Recognizing that ART allows people living with HIV/AIDS (PLWHA) to live longer, healthier and more productive lives, in 2002 the GRZ made a policy decision to make ART widely available to all its citizens. It allocated approximately US$3 million for the initial purchase of ARV drugs to be provided through the public health service.

The GRZ drafted the 2002-2005 Implementation Plan for Scaling Up Antiretroviral Treatment for HIV/AIDS. It includes building systems, human capacity and infrastructure necessary for widespread delivery of ART. The scale-up plan includes public, private, NGO, CBO, and FBO facilities. The plan includes the development of a certification system to make sure institutions have the necessary staff and capabilities to deliver ART according to the national guidelines and standards.

At present, only about 14,000 infected Zambians are receiving ART, but the GRZ aims to reach 100,000 persons by the end of 2005. The USG goal seeks to have 120,000 patients on ART nationally by 2008. Zambia now has at least 80 centers across the country providing ART: 2 referral hospitals, 9 provincial hospitals, 36 district/mission hospitals, 22 private clinics, 8

[6] Scaling-Up Antiretroviral Treatment for HIV/AIDS, National Implementation Plan 2004-2005 (Draft of 4 August 2004)

health centers in Lusaka, 1 mine hospital and 2 military hospitals.

The Zambian Defense Force (ZDF) currently has 80 persons on anti-retroviral therapy. The Defense Force Medical Service established a policy not to put more patients on ARVs until it trains medical staff on use and management of ART. Law enforcement members fail to access ARVs due to gaps in GRZ and donor support.

A recent rapid assessment of the Zambian ART program identified several important constraints including:

- Inadequate human resources for testing, counseling, and treatment related care;
- Gaps in supply of drugs in the public sector;
- Lack of adequate logistic/supply chain systems;
- Stigma which hinders people from seeking care and treatment;
- Lack of information concerning the availability of treatment services and a high level of misinformation about ART;
- Need for a continuous funding stream as cumulative patients on therapy result in a growing need for support;
- High cost of ART to the patients including drugs and testing, despite being subsidized in the public sector;
- Lack of referral between counseling and testing services and ART; and
- Lack of referral between Home Based Care services and access to testing and referral to ART.

A primary hurdle to scaling-up ART is maintaining a continuous funding stream as cumulative patients on therapy result in a growing need for support. Another major challenge is integrating Emergency Plan activities into the GRZ National Expansion Plan. The USG is committed to working closely with the GRZ to ensure coordination and support as availability of services increases.

B. USG Strategic Approaches Given USG Comparative Advantages

Meeting the Emergency Plan treatment objective of 120,000 persons receiving ART by 2008 requires far more than providing a reliable supply of essential drugs. It requires addressing complex issues such as the lack of adequate infrastructure, staff, and technical capacity to provide safe, high quality treatment programs that reach all areas of the country. The USG plans to make the most of the reduction in the price of ARVs, proven treatment methodologies, the commitment of the GRZ, and existing and potential capabilities of FBOs, CBOs and other private sector partners to rapidly scale up the ART program in Zambia.

1. Rapidly scale up treatment availability through the network model

The Emergency Plan in Zambia plans to adapt, for the Zambian context, the operational strategies for treatment scale up of The Emergency Plan Five-year Global HIV/AIDS Strategy:

Assess network capacity for treatment expansion: The USG will work with the GRZ and other cooperating agencies in assessing the current capacity of the HIV/AIDS network to scale up ART services. Using recent and ongoing assessments, and inline with the GRZ National Implementation Plan for Scaling-Up Antiretroviral Treatment for HIV/AIDS in Zambia, the USG will help define (a) current capacity of components of the network to deliver and rapidly expand treatment and related services; (b) strengths and weaknesses of the systems that support the delivery of treatment, such as referral systems, logistic systems, and management information systems; (c) potential care and treatment providers; and (d) policy issues and cultural practices that either support or inhibit the capacity to deliver treatment. The USG will also

ensure that ART service standards are monitored closely and maintained as the network expands.

Build on established clinical programs: The USG, in line with the GRZ plan for scale-up of ART availability and services, will support activities that scale-up existing programs and also focus on those facilities that do not currently provide ART but are good candidates for rapid expansion and mobilization to provide ARV treatment. The Emergency Plan will provide technical assistance and training to public health facilities, private FBOs and CBOs, and private commercial facilities to rapidly add ART to their services.

The USG will also support communication efforts to inform communities of the availability of ART services and to mitigate misunderstandings about ART. An area of treatment that has not received attention in Zambia is availability of ART services for children. The Emergency Plan plans to work closely with UTH to expand a center for outpatient pediatric and family HIV care by 2006. In addition, the Emergency Plan will support efforts to institute pediatric and family HIV care and psychosocial support units, including ART services, at 2-3 additional regional hospitals. These will serve as a core for a network of pediatric providers. These medical centers will demonstrate best practices and serve as training as well as referral centers for specialized or difficult cases.

TB is frequently the first manifestation of HIV/ AIDS and the reason many people present themselves for medical care. Through the Zambian National TB Program, DOTS has been implemented in all 72 districts of the country to varying extents, staff at health center, district and provincial levels have been trained in TB control, including both clinical management and laboratory. Community participation has been promoted and resources are available for the community TB treatment supporters. Recording and reporting occurs and Zambia is reporting annually to WHO. In 2003 the reported treatment success rate was 83.4% for cases under the DOTS program and 71.3% under non-DOTS program. Failure rates were 2.1% and 4.7% respectively. The case detection rate was reported as 79%.

Since TB treatment and HIV/AIDS treatment require longitudinal care and follow up, successful TB programs will provide an excellent platform upon which to build capacity for HIV/AIDS treatment. In order to assess this treatment model, the Emergency Plan will support a program of ART for HIV-infected TB patients in Livingstone. Using lessons learned from this activity, the USG will scale-up services to reach as many co-infected patients as possible. In addition to TB patients, USG will support efforts to promote "opt-out" counseling and testing at antenatal and STI clinics that will assist in identifying and referring eligible patients to ART. The USG team will also assist the ZDF in providing ART to military personnel.

Rapidly train and mobilize health care personnel to provide treatment services: Technical assistance and in-service training will be the primary method for building the skills of current health workers, including physicians, nurses, community health workers, pharmacists, and laboratory technicians. Training will focus on building health workers' skills to improve ART case management for both adults and children, including administering drugs, monitoring patients for side effects and treatment failure, and promoting treatment adherence. The USG plans to train laboratory personnel for testing and for critical resistance monitoring. The USG will also fund laboratory improvements and supplies. Refresher trainings will help to monitor trained staff progress and to assure quality of services (See Achieving Sustainability and Human Capacity Development).

Enhance the capacity of supply chain management systems to respond to rapid treatment scale-up: Over the next 5 years, the USG team expects to work with the GRZ to

strengthen the supply chain. Currently, ARV drugs are primarily purchased using Global Fund resources via UNICEF. The GRZ initiated a new contract for the management of their central medical stores. Concomitantly, the new USG procurement mechanism is being developed to centrally manage ARV and commodity purchases for the Emergency Plan initiative. The USG will assist the GRZ to harmonize and streamline the purchase, logistics, and management of ART drugs and supplies and help develop or enhance systems to ensure that a steady and reliable source of quality ARVs, other medicines, and supplies reach their intended recipients.

2. Build capacity for long-term sustainability of quality HIV/AIDS treatment programs

Strengthen national human resource capacity through health care workers recruitment and retention strategies, long-term training and technical assistance: The Emergency Plan in Zambia will continue to support short- and long-term training activities to include the incorporation of ART content into pre-service training programs for doctors, clinical officers, pharmacists, laboratory technologists, nurses, and midwives. These activities include (a) curriculum development to incorporate management of HIV/AIDS-related illness into the basic package of care offered through routine health services; (b) technical assistance and training to improve ART case management, including promoting adherence and monitoring patients for side effects, treatment failure, toxicity, and contraindications; (c) technical assistance and training in improved supervision and quality assurance; (d) technical assistance and training to develop and implement a process to become a "certified" ART provider; and (e) technical assistance to promote and improve treatment literacy. The USG seeks to also assist in the development and implementation of policies and initiatives to support recruitment and retention of qualified health care professionals. (See Achieving Sustainability and Human Capacity Development.)

Establish, update, disseminate, and implement treatment protocols: As needed, the Emergency Plan in Zambia supports activities to develop, update, disseminate and assist in the implementation of evidence-based national guidelines and protocols for managing ART and opportunistic infections. Through training and technical assistance, the Emergency Plan will assist in assuring the universal use of these protocols in the public health sector, private facilities, FBO and CBO treatment facilities and in conjunction with home based care. A priority need in Zambia is clinical care guidelines and ARV regimens for children, and the Emergency Plan will provide technical assistance to develop these guidelines and preferred ART regimens.

Develop the capacity of new partners: Through technical assistance and training, the USG plans to assist new partners in developing sustainable technical, managerial, and financial management skills necessary to implement ART services. The Emergency Plan aims to take advantage of the enormous human capacity and infrastructure of faith-based facilities that already provide more than one-third of the health care in Zambia. FBOs and CBOs are in the forefront of the response to HIV/AIDS in Zambia and are a major focus of technical assistance and training. The USG expects to build upon the strengths of FBOs that include very strong leadership and an excellent model of care. The USG will assist with a well-designed data management and M&E system, adequate physical space and laboratory support in selected clinics, and enough trained staff to sustain and expand the network required to deliver ART services.

In order to accomplish the 5-year objectives, the USG team will work closely with the GRZ to strengthen ties to the private sector, including both private health care providers and the broader business community. Currently, the USG provides support to two of Zambia's largest private sector employees. Lessons learned from

this support, as well as further collaborations underway, will leverage the resources of the private sector to provide comprehensive prevention, treatment, and care programs. With successful programs and the realization of cost-savings to the private sector, the objective of the Emergency Plan is to have all large Zambian employers adopt a codified HIV/ AIDS policy and program for their staff and families.

Develop and strengthen health infrastructure: Zambia has a great need for basic infrastructure in support of the ART scale-up. The USG will assist in building or expanding critical clinical infrastructure in the country. ART programs require the ability to monitor treatment and adverse events. Laboratory services will need to be expanded countrywide and work as an integrated system with quality assurance. The USG team will work through multiple agencies and cooperating partners to enhance the ability of treatment centers to monitor HIV infection. This approach will train lab managers and technicians, improve quality assurance systems, provide essential equipment and supplies, and develop laboratory infrastructure.

3. Advance policy initiatives that support treatment

Providing technical assistance in policy development: The USG will continue to assist the GRZ to develop national policies, plans, and guidelines necessary for the scale-up of ART services. The USG and its partners will continue to address health systems in a holistic manner while developing and implementing national health policies. This includes strengthening the HIV/AIDS services network by assisting in the development and implementation of policies for establishing or enhancing referral systems and by encouraging linkage of services both between and within facilities and between public and private sectors.

Build political commitment: Through technical assistance and training, the Emergency Plan in Zambia continues to encourage political commitment at the highest levels of government and works to ensure that Zambia's policies and infrastructure support this commitment. The Emergency Plan will work with formal and informal leaders from GRZ, businesses, and faith-based and nonprofit organizations to build a strong leadership cadre (See Engendering Bold Leadership).

2.4. CARE

Care Objective: 600,000 receiving care and support by 2008

A. Specific Opportunities and Challenges

In Zambia, HIV/AIDS has left over 830,000 infected adults, 85,000 infected children and 630,000 orphans in its wake. Without a robust and urgent response, the numbers that need care and support will grow exponentially over the next few years. By 2008, the Emergency Plan in Zambia will develop the systems to provide care to these adults and children by expanding counseling and testing, establishing and enhancing palliative care, developing mechanisms to treat OIs and STIs, and increasing local capacity to care for OVCs. Most importantly, the USG will work to break down the stigma barrier by generating bold leadership on all levels so that counseling and testing will be routine and integrated into the health system.

Another significant component of the USG critical interventions is increasing access to HIV counseling and testing. Few men (9%) and women (9%) have ever tested for HIV in Zambia (ZSBS 2003). Over the next 5 years, the Emergency Plan will expand targeted interventions, accompanied by rapid expansion of counseling and testing sites to accommodate increased use of HIV counseling and testing services. Through the Emergency Plan, the USG sees significant opportunity to:

- Improve availability, access and use of HIV CT, palliative care (including basic care and treatment of TB and other opportunistic infection), and OVC support services;
- Improve length and quality of life of people living with HIV/AIDS;
- Establish standards of care and quality assurance mechanisms for HIV/AIDS associated palliative care and care for OVCs;
- Increase public information and understanding of CT, palliative care, and treatment of OI;
- Create and expand linkages between CT services and care and treatment facilities; and,
- Achieve full and continuous supply of related drugs and medical supplies.

The Zambian National HIV/AIDS/TB/STI Strategic Plan identifies expanding access to and use of HIV Counseling and Testing (CT) as a critical objective. In 2000, the GRZ began to explore ways to combine available resources to expand opportunities for Zambians to seek counseling and to learn their HIV status. The Voluntary Counseling and Testing (VCT) Partnership was formed as a collaboration between government, NGOs, District Health Management Teams, and donors to expand access to high quality VCT and to promote the health and social benefits from knowing one's HIV status. The USG was a key partner in the formation of the VCT Partnership.

There are currently 250 CT sites in government and NGO-sponsored facilities. In 2003, 139,402 people received CT services nationwide (not including those tested in PMTCT programs). Most tested in public health facilities. However, KfW (the German development bank) and the USG are support the scale up of private sector stand-alone testing clinics that are closely linked to treatment and care services in their communities.

There is clearly a need to integrate routine CT into clinical health services such as those for TB and STIs. The prevalence of HIV in newly diagnosed TB patients in Lusaka is approximately 69%. TB is a major cause of morbidity and mortality in HIV infected individuals and is responsible for 40% of deaths in AIDS patients. Currently CT is not routinely offered to TB patients and is not a routine process for STI clients.

Challenges that lie ahead include the need to create greater access to palliative care services in both civilian and military populations as part of a necessary combination of health care services to counteract the burden of HIV/AIDS. The USG will build on the network model to create sound referral systems to and from ART with home-based, hospice and clinical care in order to support continuity of patient care. To support these care linkages, it is also essential to strengthen the overall health system so it can manage the increasing flow and volume of users.

With an estimated 920,000 PLWHA in Zambia, the need to rapidly expand and improve the quality of services is tremendous. Currently, the vast majority of care takes place within the home and community through faith- and community-based organizations. As more people get tested and learn their status, the demand for a continuum of care will increase. The burden of disease from AIDS has overwhelmed the medical system, leading to an ever-growing need for home-based or hospice care. There is a critical need to establish standards for palliative care, to assure a minimum set of treatments, and to strengthen the capacity of government health services, NGOs, CBOs, and FBOs to provide quality supportive care to PLWHAs within a coordinated framework relying on known national standards under GRZ oversight.

B. USG Strategic Approaches Given USG Comparative Advantages

1. Counseling and Testing (CT)

Counseling and Testing (CT) is an important link between prevention programs and referral of HIV positive persons for treatment, care, and support services. CT is the entry point to both treatment and care programs. The USG will support increasing access to and quality of CT services nationwide through public, private, and FBO supported CT clinics and the integration of CT into all clinical health services. The USG will work with the Zambia VCT Partnership to expand the number of testing sites, develop community mobilization to provide pre- and post-test support, encourage Zambians to know their HIV status, and strengthen links between CT and other prevention, treatment, and care services. Mobile VCT services will play a significant role in expanding testing services and availability.

In order to enhance access to CT, the USG will continue to support the incorporation of routine testing with an opt-out option into the PMTCT package and into other health services. As part of this effort, the USG will provide support to the GRZ to develop a program offering CT to all TB patients as a routine service.

CT activities are also critical in successful "B" – Being Faithful - activities. Knowledge of one's negative status should be an incentive to remain negative and prevent new infections. Conversely, those with a positive HIV status will have access to positive living programs, and ART if eligible. The USG will support activities that target discordant couples and that link CT to Being Faithful interventions.

Stigma remains the strongest barrier to increased CT. The USG will work with political, religious, civic, military, law enforcement, and traditional leaders to break down the stigma associated with HIV/AIDS, encouraging more Zambians to seek counseling and testing.

2. Palliative Care

Expansion of palliative care: The USG will rapidly expand palliative care services in Zambia through clinical and hospital facilities, community-based hospices and home-based care to ensure that at least 222,000 PLWHAs receive appropriate care by 2008. This rapid scale-up will be achieved through the provision of resources and capacity building for the growing network of health care providers, faith-based organizations, and community-based caregivers to enable them to both improve and expand their services. The Emergency Plan provides technical and financial support for community-based palliative care delivered in the home and in facilities.

The Emergency Plan established a rapid response sub-granting mechanism for local faith- and community-based organizations to expand and improve home based and hospice care and aims to link facility services for treating opportunistic infections, TB, and STIs as well as to provide expertise for improved pain management. The Emergency Plan also expands treatment options in military settings to allow patients to be discharged to quality home based care.

Improving the quality of care (including home-based care [HBC]): A continuum of care will be provided through a network of service delivery sites and community based programs implemented by the GRZ, ZDF, FBOs and CBOs. Through this, a broad range of services will be offered as close to the home as possible, including post-test support, an evidence-based basic care package that extends life and prevents opportunistic infections (OIs) through treatment, linkages to ART and ART adherence, and end of life care. Pain management will be integrated into clinical and hospice services and continued through community-based service delivery.

Standards of palliative care and service delivery protocols will be developed for clinical, hospice and community-based care. Staff and caregivers will be trained and quality assurance measures will be established. To address the issue of

human resource availability for palliative care, in addition to training, the USG will continue to work with the GRZ, community-based partners, and volunteers to assess and shift tasks to relieve the burden on the limited number of health care providers. The Palliative Care Association of Zambia will be supported and twinned with the African Palliative Care Association, Hospice Uganda, and Zimbabwe Home-based Palliative Care to strengthen its capacity to provide in-country technical expertise and training in HIV/AIDS palliative care. Procurement and logistics systems for the supply of drugs for OIs and presumptive care and home-based care (HBC) kits will be strengthened to ensure a consistent supply. These activities will also include the logistics required for these products often essential for HBC.

Link care services to the Network Model (Referral Model): USG agencies aims to strengthen HBC by linking services through a Network (or Referral) Model. A strong and effective referral network of services will be established among HBC organizations, hospices, and clinical facilities.

Mobilize policy change including access to pain medication: The USG will assist in establishing a palliative care policy and helping to reform regulations to increase access to pain medication within palliative care, and in establishing treatment protocols.

Link care interventions with other non-Emergency Plan USG efforts: Nutritional supplementation to the chronically ill living in food insecure households will be provided through links with Title II food aid and the World Food Program (WFP). Links with agricultural programs will provide livelihood training and resources for households most affected by chronic illness.

Integrate care services with prevention and treatment interventions: All palliative care service sites, including HBC, will be interconnected with VCT, PMTCT, TB and STI treatment, and ART service delivery, as well as other support and advocacy efforts. In parallel to these linkages will be integration of care and other services wherever possible, either through facility/service co-location, or through GIS-based mapping of geographic proximity of services to reduce travel time and cost to clients.

Strengthen and leverage the private sector: The USG will work with private clinics and hospitals to strengthen their palliative care services to meet national guidelines and protocols. In addition, the USG will work with a wide range of small, medium and large private enterprises and public sector ministries to incorporate the provision of palliative care into their HIV/AIDS workplace programs. Private corporate health facilities, such as those at Konkola Copper Mines, will be strengthened so they are able to provide high quality palliative care to their employees, families and residents of surrounding communities.

Treat opportunistic infections (OIs): In Zambia, OIs are often the first indication of an underlying HIV infection. In clinical settings, upwards of 65% of admissions are estimated to be HIV related. The GRZ, in partnership with the USG and other stakeholders, has produced standardized clinical care guidelines for the prevention and treatment of opportunistic infections. In order to ensure quality management of the HIV infected individual, the USG will strengthen the ability to diagnose and manage opportunistic infections through the provision of technical assistance for the development of quality assurance of laboratory testing, and the provision of laboratory equipment, supplies, and training.

The USG, in collaboration with the GRZ, will provide technical and logistical support to develop a program linking patients presenting with OIs, TB, and STIs to counseling and testing services as part of routine management and as a means of identifying HIV infected individuals for referral to ART programs. The management of

STIs will be strengthened through the revision of guidelines, training of health care workers, and support for the laboratory monitoring of STIs, including drug sensitivity monitoring. The improved STI services will enable more co-infected persons to be referred into treatment. The USG will provide support to strengthen the management of HIV infected individuals with TB through the DOTS program (directly observed treatment), including the use of community treatment supporters to enhance adherence to ART. The laboratory capacity to diagnose TB in HIV infected individuals and monitoring of drug resistance will be strengthened through training and the provision of laboratory equipment and supplies. A surveillance system to monitor the trends of HIV in TB patients will be developed with the GRZ.

3. Orphan Care

When mothers, fathers or both parents die from AIDS, the surviving children are traditionally taken into the households of relatives, neighbors, or friends, continue to live in their homes with the eldest child heading the household, or end up living on the streets. Guardians of these children are unable to meet the costs of basic necessities such as food, school fees and health services. In light of the large percentage of orphans being cared for by grandparents, a growing concern arises over what may happen to these children as their grandparents age. The increasing numbers of street children seen in urban centers provides an early warning that Zambian households, extended families, and the traditional community support system have been pushed to the brink of collapse.

Rapidly scale up services for orphans and other vulnerable children: The USG will build on years of experience and lessons learned in providing care and support to OVCs in Zambia. Within the next five years, the USG in Zambia will increase the number of orphans receiving care from 167,000 in 2003 to 378,000 in 2008. This rapid increase will occur by providing support to national and district OVC structures such as NAC and the Ministry of Youth, Sports and Child Development, and through a number of centrally and bi-laterally funded projects. The Emergency Plan will provide sub-grants to local FBOs/CBOs, and will link OVC care with home-based palliative care. In addition, through the centrally funded Annual Program Statement (APS), Zambia is expected to have at least 5 additional projects focused on responding to the needs of OVCs.

Working with the NAC Technical Working Group on OVCs and the National OVC Steering Committee, the USG will create a vibrant and effective OVC partnership group that will provide direction, leadership, and strategic thinking for OVC care in Zambia and will coordinate the many OVC programs in the country.

Strengthen the capacity of families and local organizations to provide care and support: The USG will provide training, capacity building opportunities and resources for improving the quality of care being provided to OVCs. This will include establishing standards of care, providing learning tools, and implementing and monitoring OVC programs. OVC programs will provide training and support to guardians of OVCs to keep the family together. Community OVC committees will identify OVCs and families in need of support and make recommendations to the FBOs/CBOs implementing the programs. Depending on the needs of individual OVCs, OVC care will include educational support, nutritional support, psychosocial support, health care, shelter, and other basic needs.

Mobilize policy changes that support OVCs: The USG will work with the National OVC Steering Committee to finalize the National OVC Policy and to develop a strategic plan for OVCs. To facilitate this process, the USG will place a consultant in the Ministry of Youth, Sport and Child Development to provide daily technical support.

Integrate orphan care with prevention/treatment/care interventions: Care for OVCs will be directly linked to palliative care programs so that when a parent dies, the children will be immediately linked to OVC services. In addition, OVC programs will be linked to youth prevention and abstinence promotion activities. For example, a scholarship fund for OVCs will also provide training in peer education and counseling for HIV prevention. OVCs found to be HIV positive will be referred to pediatric ART and family support programs for children living with AIDS. The USG will support the continuation and expansion of family support units for children living with AIDS as pediatric ART programs emerge. The USG will also provide psychosocial and post-exposure prophylaxis (PEP) or ART treatment referral services for children who have been sexually abused.

Link orphan care interventions with other non-Emergency Plan USG efforts: The USG will implement a three year project for street children through support from the Displaced Children and Orphan Fund. OVC programs will be linked to World Food Program support to community schools and other OVC activities. The USG will also work with the Ministry of Education to support continued enrollment of OVCs in school.

Strengthening and leveraging the private sector: Efforts will be made to encourage the private sector to support OVC programs and activities. For example, in Livingstone, a large five-star hotel is interested in supporting the Family Support Unit for Children living with AIDS at Livingstone Hospital.

Gender: While both boys and girls are left vulnerable from the impact of the AIDS epidemic, female orphans seem to be the first to drop out of school and are more vulnerable to sexual abuse and exploitation. Working closely with the Ministry of Sport, Youth and Child Development, OVC programs will ensure involvement of girls in OVC activities, provide support to keep them enrolled in school, and link them to livelihood programs to give them income-generating skills.

III. SUPPORTIVE INTERVENTIONS

3.1. ENGENDERING BOLD LEADERSHIP

The USG's vision for Zambia in five years will be achieved only if effective leadership has diminished stigma to marginal importance and changed cultural practices and norms that permit HIV/AIDS to flourish.

Stigma remains a silent but powerful barrier to fighting the HIV/AIDS epidemic in Zambia. The continuing stigma of HIV/AIDS affects prevention, treatment, and care. Reluctance to break the wall of silence mutes prevention messages. The prospect of ostracism reduces the number of those seeking counseling and testing, limiting the patient population for treatment programs. Stigma and ignorance also reduce community support for people living with HIV/AIDS (PLWHA) and their affected families. Embarrassment and shame, linked to sexual behavior, are still strongly felt.

Risky cultural practices, beliefs and norms promote the spread of the HIV/AIDS virus. Zambia is a deeply traditional society, in which conformity is highly valued. Harmful cultural practices include sexual cleansing, which requires a widow or widower to have intercourse with the deceased spouse's siblings. Norms prevent women in long-term relationships from demanding condom usage or denying dry sex. Destructive beliefs, such as the myth that sex with a virgin cures HIV/AIDS, persist.

A number of traditional, political, religious, uniformed service, entertainment, and civil society leaders are working to break the wall of silence around HIV/AIDS to reduce stigma and change Zambian culture. Their number continues to increase each day. However, many influential Zambians are missing from the fight against HIV/AIDS. In some cases, ignorance may lie behind their failure to enlist; in other cases, conformity and fear of stigma may be responsible. Other potential Zambian leaders are less effective than they could be because they represent groups generally held in low esteem by Zambian society, such as women, youth, or PLWHA.

During the next five years, Zambians need to fully acknowledge the emergency HIV/AIDS represents for their nation, and leaders at all levels must increase their advocacy on HIV/AIDS prevention, treatment, and care. National leaders need to elevate the importance of HIV/AIDS in their rhetoric and put their words into action by, for example, incorporating information on HIV/AIDS and the importance of abstinence into basic school curricula. Traditional leaders and healers need to eradicate harmful beliefs and practices among their followers. Faith-based leaders must create a climate in which discrimination and stigma are not tolerated. Community leaders must take responsibility for mobilizing resources to care for their members affected by HIV/AIDS. Leaders at all levels must empower the powerless, such as PLWHA, to take advantage of their voices in the battle against the epidemic.

Strategies the USG will use to promote leadership over the next five years include:

- Continuing work with associations of traditional leaders and traditional healers to battle ignorance, first among leaders and healers themselves, and subsequently, through the leaders, in communities;
- Soliciting innovative approaches to promoting leadership by establishing a grants program for promising leaders through an implementing partner;
- Providing faith-based leaders with the tools to increase abstinence and faithfulness practices;

- Empowering women and girls, youth, and PLWHAs to protect themselves, speak out and seek CT and treatment services;
- Supporting effective media, journalism, and the performing arts programming, particularly on radio, to reach remote communities with prevention messages, and information to combat ignorance/stigma;
- Using USG resources to amplify the voices of effective Zambian leaders; and
- Identifying and training/assisting leaders not currently engaged in battling HIV/AIDS but able to powerfully influence key population groups, such as athletes and entertainers.

3.2. ACHIEVING SUSTAINABILITY AND HUMAN CAPACITY DEVELOPMENT

A. Where Will Zambia be in 5 Years on the "Continuum of Sustainability?"

At the end of 5 years, Zambia will have well functioning systems and policies. Many of the Emergency Plan's partners will have the ability to independently manage programs, including technical capacity and administrative capacity. The country will still depend on financial support for drugs, medical supplies and equipment, staff and systems. Continued funding of staff retention schemes will also be required. There will still be a need for selected targeted technical assistance.

B. USG Strategic Approaches Given USG Comparative Advantage

<u>Human Capacity Development</u>

The GRZ has embarked on a plan to drastically and rapidly scale-up availability of ART, CT and PMTCT services throughout the country. However, the implementation of this comprehensive package of diagnosis, treatment and care requires already overworked and understaffed facilities to devote scarce time and resources to meet these needs. Adding to this shortfall of human resources is the emigration of trained and skilled health care workers, the "brain drain." Therefore, there is an urgent need to increase human resources, especially skilled health workers such as physicians, nurses, pharmacists and managers to address HIV/AIDS in Zambia. This cadre of workers will be developed by recruiting and training community health workers, and lay counselors, and through short-term in-country training of medical staff.

Scarce and unequal allocation of human resources for service delivery is among the biggest constraints to extending coverage of HIV/AIDS services in Zambia. Resolving the human resource crisis in Zambia will require complex action at policy, planning, regulatory, legal, management, and training levels. It will require clarifying disjointed human resource (HR) management functions currently spread across the Civil Service, Ministry of Finance, and Human Resources Division of the Ministry of Health. Close collaboration will be needed with non-governmental stakeholders such as the Medical Council and General Nursing Council. Finally, it will be necessary to address the serious morale issues and the increasing burden on health staff whose performance is affected by HIV/AIDS or the threat of HIV infection.

The burden of HIV/AIDS on the health system has been enormous. Both in-patient and outpatient services have been strained. More than 65% of hospital admissions are due to HIV/AIDS related illnesses. Other clinical and palliative care needs are also overwhelming existing staff.

The USG will assist the GRZ in identifying health care provider needs, geographic needs, training gaps and opportunities for task shifting. The improvement in communication and transportation systems that will strengthen network links will also support recruitment and retention.

The USG will support efforts to broaden responsibility for treatment, care, and support, possibly including nurses, paramedics, lay counselors and health volunteers. To further extend treatment services into the community, the USG will involve faith-based and community based organizations, traditional healers and birth attendants by training them to recognize HIV complications, provide basic home-based care, communicate key messages, and refer patients to appropriate health care. In addition, FBOs and NGOs will continue to provide clinical services.

The USG will support the development of a learning continuum across pre- and in-service training for healthcare providers to ensure that appropriate and relevant learning and continuing education opportunities occur at all stages of the provider's career. Pre-service institutions need to plan for the number of graduates and technical expectations of these graduates upon deployment as expressed within the national Human Resource plan. Similarly, the development of human resources needs to be grounded in realistic estimates of capacity of educational and training institutions to increase their intake. It must be informed by the Medical and Nursing Councils' perspectives on the competencies of health workers needed to address Zambia's health personnel requirements. In-service training must be an integral element of developing the required human capacity. The USG will assist in developing a national system that prioritizes and organizes in-service training.

An exciting strategic approach that will be implemented by the Emergency Plan in Zambia is the mutually beneficial twinning of Zambian institutions with U.S. and regional institutions that will allow for the exchange of personnel and volunteers. The twinning will include public, private and military institutions from Zambia with institutions in the U.S. and counterpart institutions in African countries. The new twinning of institutions will build on the model of longstanding institutional collaborations between Zambian and U.S. institutions in the health sector. Twinning will be established for Pediatric ART, palliative care, and for the military.
The USG will explore measures to reverse "brain drain" by the use of incentives and policies that reduce workforce attrition and attract medical professionals to return from affluent countries. The USG will explore retention scheme options for possible USG support including access to further education through scholarships, social franchising and others.

Organizational Capacity Development

The current capacity for existing health systems in Zambia to deliver HIV/AIDS prevention, treatment, and care services is limited, particularly in rural areas. To ensure rapid scale up and sustainability, the Emergency Plan in Zambia will support activities to develop or enhance organizational capacity using the existing network model organization of the health care system in Zambia. The current network includes the central medical facilities of the GRZ, provincial-level and district-level hospitals, and health centers and their community outreach workers, supplemented by private clinics

including workplace clinics, faith-based facilities, and private health care providers.

The Emergency Plan in Zambia, in support of the Zambian National Health Strategic Plan and the National HIV/AIDS/STI/TB Strategic Plan and with the intent to build long-term sustainability, will strengthen linkages between the various components of the network to build capacity of the network components and strengthen network-wide linkages in order to increase access to and more effectively deliver quality HIV/AIDS services.

The development of technical, financial, administrative and managerial capacity of all elements of the network will be a critical feature of the Emergency Plan in Zambia. The focus will be on developing organizational capacity in the context of the organization's role in the network and the integration of HIV services throughout the network. This will be done through formal training, on-the-job training, mentoring, twinning, and adherence to uniform HIV/AIDS prevention, treatment, and care protocols that are consistent with national strategies and guidelines.

The Emergency Plan will support planning, management, material inputs, and policy activities at the national level; the Emergency Plan will also support material inputs at the district level and support for additional staff through secondment, volunteers, and other methods at the facility level. Activities will also be implemented to strengthen FBO and CBO partners' technical, programming and administration capabilities.

Systems Strengthening and Coordination

The USG will direct all its health systems assistance to strengthening aspects of the system critical to improving the coverage and quality of HIV/AIDS prevention, treatment, and care services. USG supported activities will focus on national policy, planning, human resources, targeted evaluation, and sector-wide HIV/AIDS system components as well as capacity-building (discussed above) with implementation assistance at the provincial, district, hospital, health center, and training institution levels.

The USG will work with and through established processes at all levels of government and in collaboration with GRZ, ZDF, NGO, FBO, CBO, the private sector and donor counterparts and partners. This will help ensure alignment of objectives, effective targeting and efficient use of resources, monitoring and evaluation of progress toward national and Emergency Plan goal, responsiveness to new developments and learning, and sustainability.

The overall strategy for system strengthening will be to build links between national policy and implementation at all levels of the network, particularly at the district level.

These links will be improved through:

- Collaborative efforts to integrate national HIV/AIDS policies and goals with sectoral objectives under the National Health Strategic Plan and with district level implementation. Key to this effort is a common set of program targets and indicators, as well as a well functioning Health Management Information System and monitoring and evaluation system. The information system must track whether HIV/AIDS objectives are being met and adjust as necessary to make targets more realistic or implementation strategies more effective;

- Assistance in translating national HIV/AIDS strategic objectives into appropriate and effective action by the frontline health providers who deliver HIV/AIDS services;
- Capacity building for institutions and individuals in skills needed to achieve effectively functioning health systems, (Discussed above) and,
- Building and consolidating partnerships across, the public, FBO, NGO and private sectors and among the central, provincial and district levels of the health system.

The USG will strengthen the management capacity of coordinating structures, including the MOH, the National AIDS Council, provincial HIV/AIDS Task Forces, and District AIDS Task Forces, to plan and implement prevention, care and support, and mitigation programs, and promote effective manpower planning. Technical support will be provided to ensure that management within FBOs, NGOs, businesses and public ministries is trained in capacity development and is mainstreaming HIV/AIDS prevention, VCT, care and treatment in operations. To foster a more conducive policy and regulatory environment, technical support will be provided to advocate for policies, codify laws and policies, and train policy- and lawmakers and enforcers.

USG partners will continue vital work to strengthen the number and skills of health workers, the planning process for hospitals and districts, the development and implementation of national health policies, the further development of cost-sharing mechanisms, and the national logistics and management systems for drugs and health supplies. The USG will continue to be one of the main donors supporting these efforts, and the only one to address health systems issues in a holistic manner.

3.3. STRENGTHENING COORDINATION AND COLLABORATION

The Emergency Plan in Zambia has given the USG an unprecedented opportunity to more actively involve the GRZ, ZDF, the private sector, and donors in focused planning on HIV/AIDS prevention, treatment, and care activities. This coordination builds upon the existing strong partnerships among donors and government around addressing technical interventions, such as PMTCT, VCT, and integrated approaches to HIV/AIDS reduction.

The strong leadership of the Ambassador and DCM demonstrates to the GRZ/ZDF/donor community the tremendous importance of the Emergency Plan within the U.S. Mission and within Zambia. Through the Emergency Plan, and led by Ambassador Brennan and the Deputy Chief of Mission (DCM), closer coordination and planning among the GRZ, ZDF, donors, and the USG has commenced to forge a shared vision for Emergency Plan goals in the next year, and over the next 5 years. GRZ line ministers and donors actively participate in formal sessions sharing current Emergency Plan activities and upcoming plans, led by Ambassador Brennan. These formal sessions discussing the role of the Emergency Plan in Zambia and how the Plan can best interface with existing GRZ/ZDF/donor efforts have proven to be successful and productive.

In addition, technical working meetings involving GRZ, ZDF, and donors have been organized as a viable mechanism to plan the upcoming years' Country Operational Plan (COP) activities. This process helps to minimize program duplication and maximize program efficiency and impact. The meetings serve as a forum for GRZ, ZDF,

and donor input on the USG program and help to identify the gaps in HIV/AIDS programs that can be filled by other donors or the Emergency Plan.

A. Level of Coordination to be Achieved in 5 Years

In line with the UNAIDS "Three Ones" initiative, it is important that the USG work closely with the GRZ and donors on developing a harmonized HIV/AIDS action framework, building up the NAC (the coordinating mechanism), and continuing to work on an agreed national monitoring and evaluation system. Over the next year, the consultative process surrounding the Emergency Plan will be streamlined so that key GRZ and donor representatives are knowledgeable about the Emergency Plan, its directives, and its potential in Zambia. The USG aspires to ensure inclusion of key persons in the GRZ, particularly the MOH, NAC, and the ZDF, key donors, and other partners. This way, lines of communication will be simplified and work can be maximized over time.

B. USG Strategic Approaches Given USG Comparative Advantages

Building capacity of designated coordinating entities: The USG has significant opportunities to build capacity in the NAC (National AIDS Council), a Zambian government institution that provides national leadership to coordinate and support the development, monitoring and evaluation of Zambia's integrated response to prevent and combat HIV, STIs and TB. The NAC has been given the onerous task of coordinating the response to HIV/AIDS throughout Zambia.

The NAC itself is relatively new and, though staffed by highly motivated and capable individuals, requires support and strengthening through technical assistance and training as well as assistance in the development of systems for monitoring and tracking program results and impact. The USG has already begun assisting Zambia and the NAC to develop the necessary capacity to drastically scale-up ART services.

In addition to assisting the development of national policies, the USG will strengthen the NAC through its Technical Support and Capacity Building Project. The USG will also scale up by building on the demonstrated effective model in the Southern Province for strengthening District AIDS Task Forces to design, implement, and advocate for programs. These task forces will bring together a wide range of stakeholders, including FBOs, traditional leaders, parliamentary representatives, women's groups, NGOs, government, the business community, and the police and armed forces. This effort will ensure the efficient implementation of HIV/AIDS programs and effective use of resources nationwide.

C. Coordination with NAC and Zambia HIV/AIDS Strategic Plan

The USG and other donors have strengthened HIV/AIDS program coordination through extensive technical support, on the policy and systems levels. USG partners have helped to develop national policies, plans and guidelines, including the National AIDS Policy, NAC Strategy Plan, ARV Scale-up Policy and Operational Guidelines – Draft, ARV Scale-Up Implementation Strategy – Draft, National Standard Package on ART and OI Therapy – 1st Edition, and National Clinical Protocols for HIV/AIDS Care & Support – Draft. Support for policy development through the NAC will be a continued USG priority and effort. The USG will

continue to be an active participant in the CCM and in NAC Technical Working Groups.

3.4. STRATEGIC INFORMATION

A. Opportunities and Challenges

The USG works closely with the GRZ, in particular the Ministry of Health (MOH), NAC, the Central Statistics Office and other line ministries, to improve HIV/AIDS surveillance, information management, usage and exchange, and monitoring and evaluation. The USG contributes financing and technical assistance to the Demographic Health Surveys (DHS) which includes HIV testing, biennial ANC HIV/Syphilis Sentinel Surveillance (SS), Zambia Sexual Behavior Surveillance Surveys (ZSBS), Biological and Behavioral Special Surveys (BBSS), National OVC Situation Analysis, numerous other research activities related to HIV/AIDS and the facility-based Health Management Information System (HMIS). HIV/AIDS projections for district and national levels are done on an annual basis in collaboration with the Central Statistics Office and widely disseminated.

B. Surveillance

Zambia has completed 3 rounds of mature SS activities (1994, 1998 and 2002) with the 2004 survey underway. The high 'precision' of this tool as well as its low cost makes it best for monitoring trends. The DHS, a detailed periodic population based survey conducted in 1992, 1996 and 2001 included HIV testing in its last round. The Zambia Sexual Behavior Survey is another surveillance tool and is conducted every 3 years to track changes in behavior.

During the 5-year period, both surveillance methods will continue and be expanded to refugee camps and to the military. The Emergency Plan provides the opportunity to scale up service- and operations-based HIV Surveillance as well as to expand surveillance activities to include: initiating a Sample-based Vital Registration and Verbal Autopsy (SAVVY) in collaboration with the US Census Bureau; systematizing HIV Opportunistic Infection and ARV resistance surveillance; strengthening ITC and Surveillance Capacity at National Reference Laboratory; and, incorporating HIV prevalence testing into Biologic and Behavior Surveillance surveys for high risk groups.

C. HMIS

The primary clinical services monitoring system for MOH is the Health Management Information System (HMIS). The HMIS is managed by the Central Board of Health (CBOH) and is a database of nationally aggregated health data intended for program management and policy decision-making.

Currently clinic visit information is recorded in paper registers at 1,236 sites and tallied manually by health care workers. The data then feeds up through district and provincial levels and is eventually loaded into an electronic national database to facilitate retrieval of predefined statistics in tables and charts. The HMIS provides disease burden and health service delivery information. However, the national HMIS lacks a supplies management tool, and data broken down by 5-year age categories and gender – though this information exists at the facility level. Data are missing from health facilities outside the government system, including private clinics, refugee camps and the Zambian Defense Force, which do not report to CBOH and are not a part of most of the situational analyses. The USG will

continue its support to the HMIS and seek to overcome current weaknesses.

D. Other Information Systems

The USG in Zambia will focus early effort on improving the health information systems in collaboration with other donors to successfully scale up prevention, safe ARV services and HIV care generally, and solve the logistic challenges to service and supplies delivery in this developing country. The USG will work to improve the quality of information systems by providing information technology (IT) technical support, equipment, and training; creating a continuity of care information system; providing communication systems including email; establishing a new drug management software for minimizing 'stockouts' of ARVs, and other essential supplies; and contributing substantial technical assistance to revise the patient health record system to address the longitudinal needs of long term ART care and improve ART patient tracking using electronic Smart Cards and paper records.

E. Monitoring and Evaluation

The USG in collaboration with the World Bank and other bilateral and multilateral donors will provide technical support to the NAC to strengthen the National M&E framework and system. The USG will conduct the Health Facilities Survey, external quality assurance (EQA) assessment and training. The USG will support the move to use UNAIDS' Country Response Information System (CRIS+) or other similar software for M&E of health projects to better coordinate partner activities. The USG will also support establishing a national project database, Global Information Systems (GIS) mapping for NAC, and targeted evaluations such as a PLACE (Priorities for Local AIDS Control Efforts) study, situation analysis of orphans, and ARV adherence studies.

The USG Team will develop and maintain a single HIV/AIDS computerized data management and tracking system for timely and efficient data collection, analysis and reporting of Emergency Plan activities of the USG/Zambia, individual agencies and implementing partners. The USG has established a SI committee. The USG will establish an electronic or web-based mechanism for management of USG partner data to collect and monitor data quality, document projects, collect success stories, track expenditures, and generate reports of key program and impact indicators as required by the Office of the Global AIDS Coordinator.